



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BODIES IN BALANCE
4151 SW FWY #210
HOUSTON TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1688-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Requestor did not submit a position summary with their submission to medical fee dispute resolution.

Amount in Dispute: \$10,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Insurance Carrier, or its agent, did not respond to the request for medical dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2010 November 16, 2010 November 17, 2010 November 18, 2010 November 19, 2011 November 22, 2010 November 23, 2010 November 24, 2010 November 29, 2010 November 30, 2010	CPT Code 97799-CP – 8 units per day	\$10,000.00	\$8,000.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a

medical fee dispute.

2. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.
3. 28 Texas Administrative Code §134.204 sets out the medical fee guideline for workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated November 30, 2010 and January 3, 2011:
 - 1 – (216) – Based on the findings of a review organization.
 - 2 – (W1) – Workers Compensation state fee schedule adjustment.
 - 1 – Unnecessary medical treatment and or service per peer review documentation attached.

Issues

1. Did the Respondent incorrectly deny the service/treatment in accordance with 28 Texas Administrative Code §133.240
2. Is the requestor entitled to reimbursement in accordance with 28 Texas Administrative Code §134.204?

Findings

1. The insurance carrier denied disputed services with reason codes "1 – (216) – Based on the findings of a review organization", "2 – (W1) – Workers Compensation state fee schedule adjustment" and "1 – Unnecessary medical treatment and or service per peer review documentation attached." 28 Texas Administrative Code §133.240(b), effective May 2, 2006, 31 TexReg 3544, states that "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments)" Review of the submitted information finds documentation to support that the health care provider obtained preauthorization for the disputed services with preauthorization approval number 060227202 dated November 11, 2010 for 10 units starting November 15, 2010 and ending January 3, 2011. The Division finds that the insurance carrier denied reimbursement based on medical necessity for health care for which the provider had obtained preauthorization. The insurance carrier has therefore failed to meet the requirements of §133.240(b). This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. In accordance with 28 Texas Administrative Code §134.204(h)(5)(b) reimbursement shall be \$125 per hour. Per §134.204(h)(1)(B) "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR." The requestor did not indicate CARF accreditation; therefore, the hourly reimbursement shall be 80 percent of the MAR, or \$100 per hour. The requestor billed code 97799-CP for 8 hours per visit for 10 visits for a total of 80 hours x \$100 = \$8,000.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$8,000.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$8,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Signature

Date _____

1/5/12

Medical Fee Dispute Resolution Manager

Date _____

1/5/12

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

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